

REFERRAL FOR PROSPECTIVE CLIENTS

TO BE COMPLETED IN THE PRESENCE OF THE CLIENT

To complete these forms please follow the directions as stated to assist St Bartholomew's House in assessing the prospective client's application for short to medium term accommodation.

All referrals will be followed up with a telephone call.

NOTE: PLEASE PRINT

Complete all Section1 in detail as this will ensure prompt attention to your application.

SECTION 1 – PROSPECTIVE CLIENT INFORMATION

SURNAME: _____ **GIVEN NAME(S)** _____

Date of Birth: _____

CurrentAddress: _____

Contact Phone Number: _____ **(M)** _____

CRN: _____ **Payment Type** (Newstart, Pension, Allowance) _____

Medicare Number: _____ **Expiry Date:** _____

Has the client been a resident of St Bartholomew's previously? **Yes** **No**

If yes, please state when and which location: _____

Next of Kin: _____

Relationship: _____

Address: _____

Contact Number (Business Hours) _____ **After Hours** _____

Does the perspective client have any form of disability/ high needs? **Yes** **No**

If Yes, Please state, e.g. Intellectual, Physical, Mental Health, Sight, Hearing, Drug & alcohol

Please circle all answers when completing Section 2. If any Yes answers, please provide more information as directed.

NOTE: TO BE COMPLETED BY A TREATING DOCTOR OR MENTAL HEALTH CLINICIAN

SECTION 2 – MENTAL HEALTH

Is the client currently prescribed medications **Yes** **No**

If Yes, List medications: _____

Medication Dose: _____

Diagnosis: _____

Symptoms: _____

When was the client first diagnosed?
(Date) _____

Is the person on a Community Treatment Order? **Yes** **No**

If yes please provide more information

Date of Order: _____

Length of Order: _____

Conditions of Order: _____

Does the person have a history of:

- Non compliance with medication **Yes** **No**
- Alcohol and/drug dependency **Yes** **No**

If yes please give more information (Date of last use / alcoholic drink)

Has the client participated in any Rehab or Detox programs? **Yes** **No**

If yes please provide more information (Program, Date`s)

- Self harm or attempted suicide **Yes** **No**

If yes please give more information(Date of attempts, self harm behaviours)_____

- Hostility and or aggression toward other people – Verbal of Physical (please include dates of incident and nature of the incident) **Yes** **No**

Has the client been admitted to a psychiatric hospital / psychiatric ward? **Yes** **No**

If yes, please advise where, when, Length of admission, number of admissions:_____

Is the perspective client currently seeing a Psychiatrist or Mental Health Worker? **Yes** **No**

If yes, please provide the following details

Name of Doctor:_____

Address:_____

Telephone Number_____

Frequency of Visits_____

Name of Key Woker_____

Address:_____

Telephone Number_____

Frequency of Visits_____

Is there any other information that you believe is relevant in providing a safe environment for the client, other clients, visitors, carers, staff and the community of St Bartholomew's House?

Yes No

If yes please give details, and our Coordinator will telephone to discuss this with you further

Name of Key Worker _____

Contact details of Key Worker

Telephone _____ Mobile _____

Who to contact after hours

Telephone _____ Mobile _____

Name of Person completing form _____

Position _____

Signature _____ Date _____

**PLEASE ENSURE THE CLIENT COMPLETES AND SIGNS THE
ATTACHED CONSENT FORM.**

ANY ACCOMODATION OFFERED TO CLIENTS IS ON A TRIAL BASIS.

Please circle all answers when completing Section 3. If any Yes answers, please provide more information as directed.

NOTE: TO BE COMPLETED BY A COMMUNITY CORRECTIONS OFFICER

SECTION 3– PRISON RELEASE

Prison Release date: _____

Prison held in: _____

Please list all Charges /
Convictions _____

Length of Sentence _____

Length of time served _____

Is the prospective client on Parole? **Yes** **No**

How long is the
parole _____

What are the conditions of Parole (e.g. reporting to Corrective services – daily, weekly, drug counselling, Urine testing, no unsupervised access to children, not to leave the State)

What has been put in place to assist the client to re-integrate into society. (e.g. Rehabilitation programs) _____

Where will the prospective client report to? _____

Name of Parole Officer _____

Address _____

Telephone _____ Mobile _____

Who to contact after hours _____

Telephone _____ Mobile _____

Has the prospective client been incarcerated previously **Yes** **No**

If yes, please provide more details- (e.g. Dates & number of incarcerations, Charges / Convictions, Length of sentence etc)

Please list all courses, educational programs, groups completed during incarceration (e.g. anger management, sexual offenders, Drug & Alcohol counselling, First Aid, Year 11 & 12.etc)

Does the perspective client suffer with Mental Health Issues? **Yes** **No**

If yes, please state diagnosis below and have a Mental Health Profession complete **Section 2**

Does the perspective client take any medication? **Yes** **No**

If yes, please state why e.g. diabetes, epilepsy, etc

Medication Dose: _____

What is the Diagnosis: _____

Symptoms: _____

When was the condition first diagnosed?
(Date) _____

Does the person have a history of non-compliance with medication **Yes** **No**

If yes, please provide more information

Does the client have any family supports in Perth **Yes** **No**

If yes, please provide details

Name _____

Address _____

Telephone _____ Mobile _____

**PLEASE ENSURE THE CLIENT COMPLETES AND SIGNS THE
ATTACHED CONSENT FORM.**

ANY ACCOMODATION OFFERED TO CLIENTS IS ON A TRIAL BASIS.

In complete referrals will be returned, resulting in a delay in providing accommodation.

**If you have any questions relating to completing this referral please telephone our Coordinator
on 9323 5104.**

CONSENT FORM

I, (Client Name) _____ GIVE MY PERMISSION TO ALLOW THE ST BARTHOLOMEW'S HOUSE STAFF TO OBTAIN ANY INFORMATION FROM THE FOLLOWING SERVICES TO ASSIST MY APPLICATION FOR SHORT TO MEDIUM TERM ACCOMODATION.

SERVICE PROVIDER	DATE
CENTRELINK	
MENTAL HEALTH SERVICES	
DEPARTMENT OF COMMUNITY CORRECTIONS	
DISABILITY SERVICES COMMISION	
DEPARTMENT OF IMMIGRATION	
WESTERN AUSTRALIA POLICE SERVICE	
MEDICAL PRACTIONIONER	
HEALTH / TREATMENT CENTRE`S	
OTHER ACCOMODATION SERVICE`S	

CLIENT
SIGNATURE _____ DATE _____

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